Checklist of Items

To be included in Grievance and Appeals Section

of a Limited Health Services Benefit Plan

In accordance with KRS 304.17A-605(1) and ,806 KAR 17:280, Section 8, a Limited Health Services Organization (LHSO)Benefit Plan is subject to KRS 304.17A-600, 304.17A-603, 304.17A-605, 304.17A-607, 304.17A-609, 304.17A-611, 304.17A-613, and 304.17A-615. The Limited Health Services Benefit Plan must include:

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()	1.	ter be uti	insurer shall disclose, in writing, to a covered person and an insured or enrollee the ms and conditions of its limited health service benefit plan. The information required to disclosed shall include a description of the covered person's right to the following: a lization review and the procedure for initiating a utilization review if an insurer elects provide utilization review — KRS 304.17C-030(2)(g)(1).
()	2.	or hea	sclosure of the right to an internal appeal of a utilization review (UR) decision made by on behalf of the insurer with respect to the denial, reduction, or termination of a limited alth service benefit plan or the denial of payment for a health care service, and the ocedure to initiate an internal appeal — KRS 304.17C-030(2)(g)(2).
()	3.	In disclosing the availability of an internal appeal process to an enrollee, other information relating to the internal appeal process may be disclosed. In this situation, the DOI should review the disclosure and prohibit any language which may conflict with 806 KAR 17:280 Section 8, which states that:	
()		a.	The internal appeals process may be initiated by the enrollee, an authorized person, or provider acting on behalf of the enrollee;
()		b.	An enrollee, authorized person, or provider acting on behalf of an enrollee must be given at least 60 days from the receipt of a notice of an adverse determination or a coverage denial in which to file a request for an internal appeal; and
()		c.	The standard internal appeal decision must be provided within thirty (30) calendar days.